

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

PHARMACY EXAMINING BOARD

INFORMATION REGARDING LICENSURE OF A PHARMACY

"No pharmacist may dispense at any location which is not licensed as a pharmacy by the board. No person may use or display the title "pharmacy," "drugstore," apothecary" or any other title, symbol or insignia having the same or similar meanings, except for a place of practice which is licensed as a pharmacy or the board." (Ch. 450.06(1), Stats.)

"Any person who fails to license his or her place of practice as required under Chapter 450.06, Stats., may be assessed a forfeiture of not less than \$25.00 nor more than \$50.00 for each separate offense. Each day of violation constitutes a separate offense."

"Every pharmacy shall be under the control of the managing pharmacist who signed the pharmacy license application, the most recent license renewal application of the most recent amended schedule of operations. The managing pharmacist shall be responsible for the professional operations of the pharmacy. A pharmacist may be the managing pharmacist of not more than one community and one institutional pharmacy at any time and shall be engaged in the practice of pharmacy at each location he or she supervises." (Ch. 450.09(1), Stats.)

INSTRUCTION TO APPLICANT FOR LICENSURE OF A PHARMACY

COMPLETED APPLICATION MUST BE ON FILE AT LEAST 30 DAYS PRIOR TO PROPOSED OPENING DATE.

To license a **NEW PHARMACY** with the Pharmacy Examining Board, please complete steps 1 through 5 below:

1. Complete the enclosed "Application for the Licensure of a Pharmacy" (Form #609), making sure to provide all information requested on both sides of the form.
2. Prepare and submit one set of original floor plans, scaled to size, with a description of the various areas designated. Please indicate location of sink and refrigerator. (For specific floor plan requirements, please refer to Chapter Phar 6 of the enclosed copy of the Wisconsin Administrative Code Relating to the Practice of Pharmacy.)
3. Complete and submit self-inspection signed and notarized with the expected dates of compliance per Wis. Adm. Code Ch. § Phar 6.
4. Forward the above items, along with the required fee, to the Pharmacy Examining Board at the address above, at least 30 days prior to the proposed opening date. Phar 6.01 Licenses; application. Requirements and procedures for applying for a pharmacy license are specified in s. 450.06, Stats. Approved application forms are available from the board. A license application and fee shall be on file with the board at least 30 days prior to the granting of the pharmacy license. A pharmacy may not operate unless a pharmacy license has been granted. Board action shall be taken within 60 business days of receipt of a completed pharmacy application, as provided in s. RL 4.03.
5. Contact the Federal Drug Enforcement Administration for registration forms at www.deadiversion.usdoj.gov, (312) 353-1236, DEA, 230 South Dearborn Street, Ste. 1200, Chicago, Illinois 60604.

State of Wisconsin Department of Regulation & Licensing

To license a pharmacy because of a **CHANGE OF OWNERSHIP** or **LOCATION CHANGE**, please complete steps 1 through 6 below:

1. Complete the enclosed "Application for the Licensure of a Pharmacy" (Form #609), making sure to provide all information requested on both sides of the form.
2. Prepare one set of original floor plans, scaled to size, with a description of the various areas designated. Please indicate location of sink and refrigerator. (For specific floor plan requirements, please refer to Chapter Phar 6 of the enclosed copy of the Wisconsin Statutes and Administrative Code Relating to the Practice of Pharmacy.)
3. Completed self-inspection signed and notarized with the expected dates of compliance per Wis. Adm. Code Ch. § Phar 6.
4. Forward the above items, along with the required fee, to the Pharmacy Examining Board at the address above, at least 30 days prior to the proposed opening date. Phar 6.01 Licenses; application. Requirements and procedures for applying for a pharmacy license are specified in s. 450.06, Stats. Approved application forms are available from the board. A license application and fee shall be on file with the board at least 30 days prior to the granting of the pharmacy license. A pharmacy may not operate unless a pharmacy license has been granted. Board action shall be taken within 60 business days of receipt of a completed pharmacy application, as provided in s. RL 4.03.
5. Contact the Federal Drug Enforcement Administration for registration forms at www.deadiversion.usdoj.gov, (312) 353-1236, DEA, 230 South Dearborn Street, Ste. 1200, Chicago, Illinois 60604.
6. A Closing Affidavit must be completed and notarized by the former owner and forwarded to the board office within 10 days of actual closure date.

Section 450.06(3), Stats., requires that a new pharmacy license be obtained following a change of ownership.¹ The following chart sets forth when a change of ownership is deemed to have occurred or not occurred. Following the issuance of a new license, that new licensee must also renew that new license at the next required renewal date, regardless of when that new license was issued.

OWNER	TRANSACTION	CHANGE OF OWNERSHIP?
Individual	Sells pharmacy to another	YES
Individual	"Incorporates" him or herself and there are no other shareholders	NO [only a change in business <u>form</u> of owner]
Individual	Incorporates and adds shareholders other than self, or goes into partnership with other(s)	YES
Partnership	Sells pharmacy to another	YES
Partnership	Members of partnership change <u>and</u> dissolves; e.g., individual(s) leaves	YES
Partnership	Members of partnership change, but partners vote not to dissolve unanimously or by partnership agreement	NO
Partnership	Partnership decides to incorporate itself	NO [again, only a change business <u>form</u> —as long as no shareholders added who were not partners before]
Corporation ²	Change in shareholders (including sale of all stock)	NO [Corporation owns pharmacy—not shareholders]
Corporation	Sells all assets (as opposed to stock)	YES [One asset being sold is pharmacy; corporation no longer owns it after asset sale]
Corporation	Becomes a subsidiary or division of another corporation	NO [Corporation still owns pharmacy, regardless of who owns corporation]
Corporation	Merges into/or consolidates with another corporation <u>and</u> loses corporate "identity"	YES

¹ §450.06(3), Stats., provides in relevant part as follows:

No pharmacy may be opened or kept open for practice following a change of ownership . . . unless the pharmacy is licensed for the new owner . . . notwithstanding any remaining period of validity under the pharmacy's license under the previous owner . . .

² Limited Liability Companies created under Ch. 183, Stats., are the same as Corporations for change of ownership.

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PHARMACY EXAMINING BOARD

REQUEST FOR THE REMODEL OF A PHARMACY INFORMATION SHEET

PLEASE NOTE: A remodel may not begin until you receive confirmation of approval directly from the board office.

Per Wisconsin Administrative Code § Phar 6.04 (4) **Professional Service Area Remodeling:** *Any modifications of the approved floor plan shall be submitted to and approved by the board or its designee. Board action must be taken within 60 days.*

To request a remodel with the Wisconsin Pharmacy Examining Board, please provide the following information to the board **in writing** addressed to, The Department of Regulation and Licensing, Pharmacy Examining Board, P.O. Box 8935, Madison, WI 53708.

1. Pharmacy name, location and state license number.
2. The managing pharmacist.
3. Pharmacy store hours (Daily, Saturday, Sunday)
4. List barrier and what type (if changing) per Wis.Admin. Code § 6.04 3(1).
5. Enclose a copy of **current** and the **proposed** floor plan (scaled to size) indicating the location of the sink and refrigerator with prescription counter space clearly indicated.
6. Indicate if the pharmacy will be closed during the remodel. If so, please provide in detail the proposed plan for closure and transfer/storage/security for controlled substances.
7. A self inspection report must be completed for the remodeled area and submitted to the board at the end of the remodel. This may be obtained on the department web site at www.drl.state.wi.us. **(Please make sure to download both sections labeled pharmacy self- inspection.)**
8. If you are creating a separate temporary pharmacy area to be used during the remodeling of the permanent pharmacy location, you must also complete and submit to the board a proposed floor plan for the area to be used on a **temporary basis**, along with a completed self inspection report. This procedure must be followed to allow for board review and approval of the temporary pharmacy area **before** beginning the remodel process of the permanent area.

Once your request is received it will be reviewed by the board office for further action.

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PHARMACY EXAMINING BOARD

PHARMACY VARIANCE REQUEST INFORMATION SHEET

To request a variance with the state of Wisconsin Pharmacy Examining Board please submit the following **in writing** to, The Department of Regulation and Licensing, Pharmacy Examining Board, PO Box 8935, Madison WI, 54308-8935.

Please be advised that all variance requests must be submitted and approved by the board at their monthly meetings and this may take an extended period of time for approval. Please submit requests **in advance** to ensure no further delays.

1. Submit the pharmacy's DBA name, location and license number.
2. Provide a contact person with a phone number if the board has further questions.
3. Indicate the specific administrative rule and variance requested.
Note- A variance may only be granted if it is authorized in the rule.
4. Explain why the variance is necessary and specifically indicate how the requested activity or practice will differ from what is authorized by the rule.
 - a. For each specific activity or practice involved indicate the specific rule for which a variance is being sought, and the authority which authorizes the variance.
 - b. Specifically identify how the proposed variance will meet professional standards for patient safety and confidentiality, including specifically each step in the prescription order handling/dispensing process to address: security, work flow delineation and accountability and pharmacist supervision over each step in the process.
5. All variance requests should be submitted to the board at least 2 weeks prior to the next regularly scheduled board meeting in order to be placed on the agenda for that meeting. Call the department for information regarding the dates of regularly scheduled board meetings.

Note - A variance that is granted by the board is only valid for the specific licensed pharmacy location to which the variance applies and for the specific acts to which the variance applies at that location. If any specific act or practice for which a variance was granted is subsequently discontinued the board must be notified in order that the variance can be rescinded for that specific licensed pharmacy location.

If any specific act or practice for which a variance was granted is subsequently proposed to be modified the board must be notified first and a new variance obtained for that modified act or practice.

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PHARMACY EXAMINING BOARD

BUSINESS MODELS AND THE REQUIREMENTS FOR LICENSURE

(PHARMACY, PRESCRIPTION DRUG DISTRIBUTOR AND DRUG MANUFACTURER)

Drug Manufacturers:

1. Drug or device manufacturing facilities which are located within the state of Wisconsin are required to obtain a manufacturer's license from the board. If the Wisconsin facility also directly distributes these pharmaceuticals at wholesale a distributor's license is also required.
2. A corporate headquarters for a drug manufacturer, located in this state, does not need to be licensed as a manufacturer if the headquarters is not a facility where manufacturing occurs.
3. A drug manufacturer may retain title to prescription drugs distributed to pharmacies until the medications are actually sold to a consumer pursuant to a prescription order. The pharmacy laws in this state do not prohibit the business arrangement proposed.
4. A distributor's license would be required for an out-of-state manufacturing facility if it engages in the wholesale distribution of prescription drugs or devices in this state from that manufacturing facility.
5. Any other distribution facility located in-state or out-of-state, whether or not owned by the manufacturer, must be licensed as a distributor if it engages in the wholesale distribution of prescription drugs or devices in this state.
6. "Wholesale distribution" means distribution of prescription drugs or devices to persons other than a consumer or patient but does not include intracompany sales, which include any transaction or transfer between any division, subsidiary, parent, affiliated or related company under the common ownership and control of a corporate entity. This means that a manufacturer can ship prescription drugs and devices from its manufacturing facility (in-state or out-of-state) to a distributor facility (in-state or out-of-state) which are both under common ownership or control without the need for the manufacturing facility to also be licensed as a distributor.

Prescription Drug Distributors:

1. A distributor's license authorizes a facility to sell prescription drugs or devices to pharmacists, pharmacies, researchers, hospitals, authorized agents of the federal government and other distributors. [See, sec. 450.07 (3), Wis. Stats.]. A distributor's license does not authorize a facility to dispense prescription drugs directly to patients pursuant to a prescriber's prescription order. Dispensing directly to patients under a prescription order requires a pharmacy license.
2. Out-of-state or in-state wholesale distributors of prescription drugs are required to obtain a distributor's license in Wisconsin for each facility from which the prescription drugs are distributed.

State of Wisconsin Department of Regulation & Licensing

3. Distribution by company A of prescription drugs under the label of company B. A distributor's license is required in this state for the facility that distributes a prescription drug into (or in) Wisconsin, irrespective of where that facility is located. The fact that the distributor (company A) may also manufacture the product under a different label does not require a separate manufacturer's license unless the facility is physically located in this state. Nor does Wisconsin law require that the entity whose label is being utilized (here, company B) be licensed as a distributor or manufacturer in this state.
4. Company A recently acquired ownership of certain prescription and OTC products previously distributed by company B along with the right to the use company B's name. The products, themselves, will continue to be distributed from facilities which are currently licensed as wholesale distributors in this state. Company A does not own or operate any of the licensed distributor facilities. Company A is not required to obtain a wholesale distributor's license from this state. A distributor's license is required in Wisconsin for each facility which distributes prescription drugs at wholesale. Although the ownership of the prescription medications being distributed at wholesale has changed, the owner of the licensed distributor facilities has not. Mere "ownership" of prescription drugs or devices being distributed does not require a distributor's license.
5. "Wholesale distribution" means distribution of prescription drugs or devices to persons other than a consumer or patient but does not include intracompany sales, which include any transaction or transfer between any division, subsidiary, parent, affiliated or related company under the common ownership and control of a corporate entity.

Out-of-State Pharmacies:

1. This state does not require a Wisconsin pharmacy license be obtained by pharmacies licensed in another state which dispense prescription medications, including schedule II controlled substances, by mail or other delivery to patients in this state. Wisconsin does not license out-of-state pharmacies at this time.

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PHARMACY EXAMINING BOARD

PHARMACY LICENSE APPLICATION

COMPLETE APPLICATION MUST BE ON FILE AT LEAST 30 DAYS PRIOR TO PROPOSED OPENING DATE.

<input type="checkbox"/> NEW PHARMACY	TYPE OF PHARMACY: <input type="checkbox"/> COMMUNITY <input type="checkbox"/> INSTITUTIONAL	CURRENT LICENSE NUMBER: _____ <input type="checkbox"/> CHANGE OF OWNERSHIP <input type="checkbox"/> CHANGE OF LOCATION
---------------------------------------	--	---

PLEASE TYPE OR PRINT IN INK.

APPLICANT: individual, partnership, association or corporation

DBA: Name or title under which business is operated. (This must be the name on the pharmacy label.)

TELEPHONE NO. (area code)

FAX NO.

PHARMACY ADDRESS: number, street, city, zip code

COUNTY

MAILING ADDRESS UNTIL DAY OF OPENING: number, street, city, zip code

NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS OR CORPORATE OFFICERS AND PERCENTAGE OF OWNERSHIP.

NAME

%

NAME

%

DATE OF PURCHASE OF PHARMACY - date of sale to be signed

PROPOSED
OPENING DATE

PROPOSED
CLOSE DATE
(if applicable)

BARRIER-per
Wis. Admin. Code
Phar 6.04 3(1)*

☐ Yes ☐ No

PHARMACY HOURS - Daily (open - close)

Saturday (open - close)

Sunday (open - close)

SUNDRY HOURS - Daily (open - close)

Saturday (open - close)

Sunday (open - close)

ENCLOSE FLOOR PLANS - scaled to size, location of sink and refrigerator with prescription counter space clearly indicated.

***Wis. Admin. Code 6.04 3(1)** – A secured, physical barrier surrounds the professional service area of the pharmacy and precludes access to the area by unlicensed personnel. A secured barrier may be constructed of other than a solid material with a continuous surface. If constructed of other than a solid material, the openings or interstices in the material shall not be large enough to permit removal of items from the professional service area by any means. Any material used in the construction of the barrier shall be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated or bent. The plans and specifications of the barrier shall be submitted to the board for approval.

APPLICATION FEE: Please make check payable to Department of Regulation and Licensing and attach to application.

\$53.00 Initial Credential Fee

For Receipting Use Only

State of Wisconsin Department of Regulation & Licensing

-
1. HAS THE APPLICANT PREVIOUSLY (OR CURRENTLY) BEEN LICENSED TO OPERATE A PHARMACY IN WISCONSIN?
☐ YES ☐ NO If yes, give license number(s): _____
-
2. IS THE APPLICANT REGISTERED OR LICENSED IN ANY OTHER PROFESSION(S)?
☐ YES ☐ NO If yes, state what profession(s) and in what state(s): _____
-
3. DOES THE MANAGING PHARMACIST LISTED ON THIS APPLICATION HAVE ANY FELONY OR MISDEMEANOR CHARGES PENDING AGAINST THEM?
☐ YES ☐ NO If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges).
-
4. HAS THE MANAGING PHARMACIST LISTED ON THIS APPLICATION EVER BEEN CONVICTED OF A MISDEMEANOR OR A FELONY?
☐ YES ☐ NO If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges).
-
5. HAS THE MANAGING PHARMACIST LISTED ON THIS APPLICATION EVER HAD A PHARMACIST LICENSE LIMITED, SUSPENDED, REVOKED OR REPRIMANDED IN THIS OR ANY OTHER STATE?
☐ YES ☐ NO If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.
-
6. HAS ANY OWNER, PARTNER, SHAREHOLDER OR CORPORATE OFFICER, CURRENTLY POSSESSING MORE THAN A (20%) TWENTY PERCENT OWNERSHIP INTEREST IN THE APPLICANT EVER HAD A PHARMACIST LICENSE LIMITED, SUSPENDED, REVOKED OR REPRIMANDED IN THIS OR ANY OTHER STATE?
☐ YES ☐ NO If yes, attach a sheet providing details about the action including the name of the credentialing agency and date of action.
-
7. HAS ANY OWNER, PARTNER, SHAREHOLDER OR CORPORATE OFFICER, CURRENTLY POSSESSING MORE THAN A (20%) TWENTY PERCENT OWNERSHIP INTEREST IN THE APPLICANT EVER BEEN CONVICTED OF A MISDEMEANOR OR A FELONY?
☐ YES ☐ NO If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges).
-
8. DOES ANY OWNER, PARTNER, SHAREHOLDER OR CORPORATE OFFICER, CURRENTLY POSSESSING MORE THAN A (20%) TWENTY PERCENT OWNERSHIP INTEREST IN THE APPLICANT HAVE ANY FELONY OR MISDEMEANOR CHARGES PENDING AGAINST THEM?
☐ YES ☐ NO If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges).
-

State of Wisconsin Department of Regulation & Licensing

This is to certify that I have read and approved the foregoing and the statements are true and correct to the best of my knowledge and belief; that I will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board and that I understand I am to be responsible for any violation(s) occurring during my tenure.

Signature of Managing Pharmacist

Date

Wisconsin License # _____

INSPECTION: Please forward the completed self-inspection form to the Pharmacy board office. Within one year from date of licensure a representative of the Board will perform an audit of the pharmacy.

We will be ready for inspection any time after: _____.

I/We declare that the foregoing statements are true and correct to the best of my/our knowledge and belief; the license applied for is to cover only the pharmacy indicated above and at the location specified; and that I/we will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board.

Applicant Signature

Title

Date

PRINT NAME of person signing above

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ADDENDUM TO APPLICATION – BUSINESS ENTITIES

Information requested is required for processing.

EMPLOYER IDENTIFICATION NUMBER. Your employer identification number must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

Business Entity Name

			-			-				
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FEIN

Type of Credential applying for

The Department may not disclose the employer identification number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

DELINQUENT STATE TAXES; DELINQUENT SUPPORT

All applications for professional credentials are checked to determine whether the applicant is liable for delinquent state taxes. Under state law, the department must deny your application if you are liable for delinquent Wisconsin taxes.⁶ If you are liable for delinquent state taxes, pay the delinquent amount before the application process is completed. Retain proof that you have satisfied the tax delinquency. If you have any questions about payment of delinquent taxes, please contact your nearest Department of Revenue office or call (608) 261-6249. An application may be denied or a credential suspended if an applicant or credential holder is delinquent in paying support or fails to comply with a subpoena or warrant issued by the department of workforce development or a county child support agency related to support or paternity proceedings.²

#2552 (11/02)

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996

⁵ Section 440.14, Wis. Stats.

⁶ Section 440.12, Wis. Stats.

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

Committed to Equal Opportunity in Employment and Licensing

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) _____

Mail To Address (if different) _____

Date of Birth _____ month day year	Social Security Number _____ Information helps us identify your record, but is voluntary. It is not available to the public.
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Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

<u>OFFENSE</u>	<u>DATE</u>	<u>CITY/STATE</u>

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED
☐ ☐
Did you successfully complete the program? ☐ ☐
Please attach the certificate of completion/discharge summary.

(Check all that apply)

4. Have you ever been sentenced to: YES NO MO/YR COMPLETED
☐ Probation ☐ ☐
☐ Parole ☐ ☐
☐ Ordered to pay restitution ☐ ☐
Did you successfully complete one of the above as ordered by the court? ☐ ☐

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
-----------------------	-----------------------	--

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

Signature _____	Date _____
-----------------	------------

Signed and sworn before me this _____ day of _____, 20 _____.

Signature of Notary Public _____	Date _____
----------------------------------	------------

My commission (is permanent) _____ expires _____.

SEAL

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PHARMACY EXAMINING BOARD

PHARMACY CLOSING AFFIDAVIT

Information requested is required for processing.

☐ CHANGE OF OWNERSHIP

☐ OUT OF BUSINESS

☐ CHANGE OF LOCATION

☐ REMODEL

Closing Date: _____

Please TYPE or PRINT in INK

I hereby certify the below named pharmacy closed on _____ and the following action was taken:
(date)

PHARMACY: _____

ADDRESS: _____

number, street

city, state, zip code

ALL NON-CONTROLLED PRESCRIPTION DRUGS REMOVED FROM PREMISES AND RECEIVED BY:

NAME: _____

ADDRESS: _____

LICENSE #: _____

LICENSE #: _____

Managing R.Ph. _____

License #: _____

TRANSFERRED PRESCRIPTION FILES TO:

NAME: _____

ADDRESS: _____

LICENSE #: _____

ALL CONTROLLED DRUGS SUBJECT TO FEDERAL CONTROLLED SUBSTANCES ACT DISPOSED OF IN ACCORDANCE WITH 21 CFR 1307.21.

Transferred to:

Name: _____

Address: _____

Date of Final Inventory _____

Date of Transfer _____

FED. CSA REG. NO. _____

DEA Form #222 _____ YES _____ NO

1. Removed all drug signs and all symbols, insignia, etc., indicating the presence of a pharmacy. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO _____ N/A If yes, date: _____

State of Wisconsin Department of Regulation & Licensing

2. Informed the telephone company in writing to remove all listings from the classified telephone directory. A copy of the letter is attached. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO

3. Discontinued use of checks, stationery, wrapping paper, bags, etc., containing the words drugs, pharmacy, etc., or symbols indicating the operation of a pharmacy or the sale of drugs. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO _____ N/A If yes, date: _____

4. Current pharmacy renewal license is enclosed. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO

5. Forward a copy of this affidavit, DEA Certificate of Registration, and any unused DEA Form 222 Order Forms to: DEA, Attn: Registration, 230 S. Dearborn St., # 1200, Chicago, IL 60604. (For out of business pharmacies only. Not required for remodel requests.)

AFFIDAVIT OF MANAGING PHARMACIST

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Managing Pharmacist Signature

Date

State of _____
County of _____

Subscribed and sworn before me this _____ day of _____, 20____
by _____

SEAL

Notary Public, State of _____
My commission expires: _____

NOTE: This affidavit must be signed by the Managing Pharmacist in the presence of the notary public on the same date.

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 267-1803
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.^a An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/02) ss. 15.04 (1) (m), 19.35, Stats.

^a Section RL 4.06 of the Wisconsin Administrative Code